

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

16293

1. PLACE OF DEATH

County..... Registration District No. 701
 Townshp..... Primary Registration District No. 1000
 City St. Louis, Mo. (No. 5600, Arsenal)

File No.....
 Registered No. 4332
 St. 24th Ward

2. FULL NAME

Lydia Griffith

(a) Residence. No. 3411 Chippewa St. 16 Ward.
 (Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 10 mos. 0 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 11-1909

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 10 0

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stenographer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St. Louis, Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Lugh Griffith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dawa
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Lydia Dawes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis, Mo.
 (STATE OR COUNTRY)

14. INFORMANT Miss Mae Madrick
 (Address) DeSales Hospital

15. ADD 13 1929 Ray C Stanley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/11 1929
 17.

I HEREBY CERTIFY, That I attended deceased from 4/3, 1929, to 4/11, 1929 that I last saw her alive on 4/11, 1929, and that death occurred, on the date stated above, at 11:55 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitis, Meningococic
18

CONTRIBUTORY (SECONDARY) Nephritis, Acute
 (duration) yrs. mos. 11 da.

18. WHERE WAS DISEASE CONTRACTED 3411 Chippewa
 IF NOT AT PLACE OF DEATH?

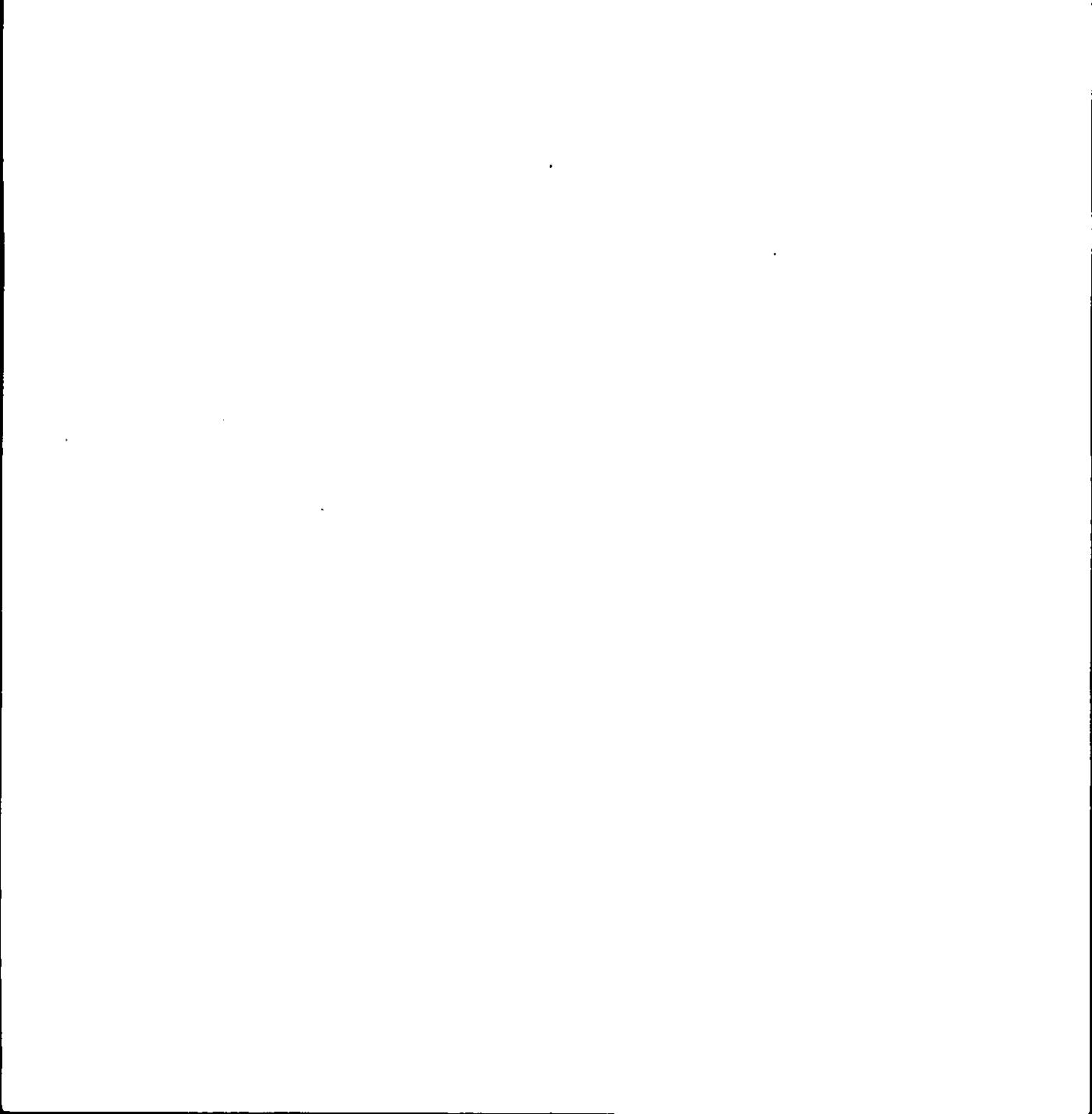
DID AN OPERATION PRECEDE DEATH? No DATE OF 4/11
 WAS THERE AN AUTOPT? No

WHAT TEST CONFIRMED DIAGNOSIS Culture
 (Signed) Dr. G. H. White, M. D.
4/11, 1929 (Address) 700 Arsenal St

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Peter & Paul DATE OF BURIAL Apr. 15 1929

20. UNDERTAKER Wacker-Keldale ADDRESS 2331 S. Bidney



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis Registration District No. 791 File No. _____
 Township _____ Primary Registration District No. 1803 Registered No. 4337
 City St. Louis No. _____ St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Lydia Griffith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (circle the word) ✓

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 11 - 1910 - 1910

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
11 8 10 -

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT (Address) _____

15. FILED JUN 23 1925 May C. Starnes REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/11 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.
 _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) _____, M. D.
 _____, 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER Hacker W. ADDRESS _____

SUPPLEMENTARY

S-16293